STATEMENT OF SENATOR ARLEN SPECTER

Cosponsorship of S.334, the Healthy Americans Act

Mr. SPECTER. Mr. President, we are facing a grave situation in America where millions of Americans do not have health insurance coverage. As the cost of health care is increasingly prohibitive and access to insurance is reduced, the number of uninsured will continue to climb.

It is estimated that nearly 47 million Americans are without health insurance. This includes the nearly 38 million individuals who have full or part time employment and still are without health care coverage. Of significant concern is the number of young adults lacking insurance: with an estimated 28 percent of those young people without insurance.

Individuals without insurance suffer from both acute and far reaching consequences. It ultimately compromises a person's health because he or she is less likely to receive preventive care, more likely to be hospitalized for avoidable health problems, and more likely to be diagnosed in the late stages of diseases. Additionally, lack of insurance coverage leaves individuals and their families financially vulnerable to higher out-of-pocket costs for their medical bills.

It is my belief that we can and should fix the problems felt by uninsured Americans with a system that does not resort to a single payer system and one that involves the private insurance industry. We must enact reforms that enhance our current market-based health care system.

The legislation I want to discuss today is S.334, "The Healthy Americans Act," which would provide access to health insurance for all Americans. Senator Wyden introduced this legislation on January 18, 2007, and since then, it has gained support from an impressive group of bipartisan Senators, including Bennett, Alexander, Nelson from Florida, Gregg, Coleman, Grassley, Landrieu, Stabenow, Crapo, Lieberman, Carper, Inouye, Corker, Smith and Cantwell. Today I am pleased to add my name to the list of cosponsors of S.334.

The Healthy Americans Act uses the private health insurance market to ensure that all Americans have access to a quality plan they can afford. This legislation has a number of components that will address the problems that plague our current health insurance system.

To begin, S.334 provides so-called "portability," which allows individuals to retain their health insurance regardless of the job they hold. In today's changing society, many Americans no longer stay with the same employer for long periods of time. Moving from job to job may mean the loss of health insurance, a new insurance carrier, or a gap in health care. The Healthy Americans Act seeks to provide consistent insurance coverage in a fluid job market.

Additionally, the Healthy Americans Act offers assistance for those who need it most by providing premium assistance for individuals and families with incomes below 400 percent of the poverty level (or $41,600 and $84,800 respectively). This provision aids those individuals that are employed but their income is insufficient to afford insurance. The assistance is based on a sliding scale with those with lower incomes receiving the greatest help. Individuals below 100

percent of the poverty level ($10,400 for an individual or $21,200 for a family) receive full assistance with their insurance premiums.

While I am cosponsoring this legislation, I have some concerns that need to be addressed as the debate on this important issue moves forward. For instance, the potential new tax obligations associated with the Healthy Americans Act on both individuals and on businesses warrant further consideration. Concerns have been raised that this bill is not tax-neutral, meaning that new tax obligations created by this legislation are not completely matched by new or increased tax benefits. This resulting imbalance, or lack of tax-neutrality, is argued by some to be a tax increase. Specifically, individuals would be required to pay their insurance premiums through the federal tax withholding system, as opposed to the current model where premiums are paid to insurers through their employer. Payments would pass through the IRS on the way to newly created regional purchasing organizations called "Health Help Agencies" (HHAs) and ultimately to the private insurer. The payment system, or collection, is technically a tax because it is being collected by the IRS. However, it is important to note that the government will not keep those dollars and will not have discretion over how they are spent. Nevertheless, this payment system deserves further analysis on the issue of tax-neutrality.

S. 334 would require all businesses to pay an assessment of between 2 percent and 25 percent of average per worker premiums. The rate paid depends on the number of people it employs. I have concerns that this provision is structured as a tax. However, it is important to note that businesses would see some benefits as a result of the bill. They would be freed from

the administrative burden of providing healthcare for employees because the individual would carry the responsibility of obtaining a private plan.

Because employers would be required to pay increased wages (in lieu of providing a health plan), they would also be subject to additional payroll tax obligations (i.e. Social Security and Medicare). An employee's increased payroll tax obligation is offset by a tax deduction provided in the bill. There is no corresponding deduction for the employer to offset their additional payroll tax obligations and one should also be considered, because the bill's purpose is not to increase payments to Social Security and Medicare. The sponsor's intention of maintaining a budget-neutral bill is also worth consideration.

The mandate of paying increased wages only lasts for two years under the bill, after which time market forces would determine total compensation. Consideration should be given to retaining the employer payroll increase indefinitely to defray the cost of health insurance. Market forces may not sufficiently compensate employees when an employer decides to cut wages beyond the two year time frame. This would harm an employee's ability to purchase health insurance.

I am also concerned with the elimination of specific tax benefits for corporations that do business abroad, though it is my understanding that the sponsors are not wedded to elimination of these specific items. The argument has been made by proponents that the Wyden bill makes U.S. firms more competitive internationally because it removes the burden on employers to administer healthcare plans for their employees. Often foreign firms do not have that burden.

To that end, the sponsor has chosen to eliminate certain tax preferences to multinational corporations as a way to raise revenue. I believe that greater consideration should be given to whether the benefit to employers of not having to administer a healthcare plan outweighs the elimination of these provisions.

First, the elimination of the Section 199 manufacturing deduction raises concerns for our exporters. The Section 199 deduction allows manufacturing firms of all kinds to take a tax deduction for their U.S.-based business activities. The deduction was 3 percent in tax years 2005 and 2006, 6 percent in tax year 2007, and is scheduled to be 9 percent by 2010. This tax benefit was enacted as part of the so-called "FSC/ETI" legislation in 2004 to replace an export tax incentive that was ruled to be in violation of our international trade commitments. At the same time, it sought to boost the ability of manufacturers to compete in the global marketplace.

Second, the bill would eliminate deferral of income from foreign corporations that are owned by a U.S. parent company. Under current law, U.S. taxes do not apply to the foreign income of U.S.-owned corporations chartered abroad. As a result, a U.S. firm can indefinitely defer U.S. tax on its foreign income as long as the foreign subsidiary's income is reinvested overseas. U.S. taxes apply when the income is repatriated back to the U.S. Ending this deferral strategy could have the negative impact of encouraging the U.S. parent firm to relocate abroad or to limit the size of their operations in the US.

S.334 also requires all Americans to obtain health insurance. Eligible insurance plans include not only those purchased through this program, but health care coverage through

Medicare, the Department of Defense, the Department of Veterans Affairs, Indian Health Service, or a retiree health plan. I am concerned that this mandate will put a burden on individuals and families that may not be able to afford the program despite assistance.

This concern is shared by fellow cosponsor Sen. Chuck Grassley who stated that "… the act would require all individuals to buy health insurance. I support accessibility to private insurance and differ with my colleagues on this point." This is an issue that must be more closely examined.

This bill also holds the Blue Cross/Blue Shield Standard Plan provided under the Federal Employees Health Benefit Program as the standard for the program. While I believe that everyone should have access to this level of coverage, it does not allow for variety in the types of insurance plans that would be available under the program. The current market allows for different types of plans, which should be available under the Healthy Americans plan. When Sen. Norm Coleman signed on as a cosponsor of S.334, he similarly noted "While I certainly believe people should have access to this level of coverage, I don't think it should be the only option. My vision of health reform does not include this one-size-fits-all approach. Instead, I support giving people access to a variety of health insurance options and the ability to make informed choices."

The vetting of this bill is already underway. Senators Wyden, Bennett, Grassley and Stabenow have taken steps to provide flexibility in the program by allowing businesses and employees to choose the best health insurance program for employees. An amendment has been

filed to allow businesses to continue to offer health insurance to employees under the current system, yet employees would still have the option to enter the Health Help Agency and obtain a Health Americans Private Insurance plan.

While these concerns are important and should be addressed, this bipartisan effort makes an important step forward in the ongoing quest to provide health insurance to all Americans. I believe the Healthy Americans Act contains excellent ideas and should be the basis for future discussions on health insurance reform. This sentiment is shared by Sen. Judd Gregg, who when he joined this bill, stated "that by joining forces with colleagues on both sides of the aisle on a private market approach, we can begin a bi-partisan dialogue, work through our differences, and find workable solutions that will result in a better health care system for all."

I look forward to working with my colleagues to provide a health insurance system that can provide quality healthcare to all Americans.

I have advocated health care reform in one form or another throughout my 28 years in the Senate. My strong interest in health care dates back to my first term, when I sponsored S. 811, the Health Care for Displaced Workers Act of 1983, and S. 2051, the Health Care Cost Containment Act of 1983, which would have granted a limited antitrust exemption to health insurers, permitting them to engage in certain joint activities such as acquiring or processing information, and collecting and distributing insurance claims for health care services aimed at curtailing then escalating health care costs. In 1985, I introduced the Community-based Disease Prevention and Health Promotion Projects Act of 1985, S. 1873, directed at reducing the human tragedy of low birth weight babies and infant mortality. Since 1983, I have introduced and cosponsored numerous other bills concerning health care in our country.

During the 102nd Congress, I pressed the Senate to take action on the health care market issue. On July 29, 1992, I offered an amendment to legislation then pending on the Senate floor, which included a change from 25 percent to 100 percent deductibility for health insurance purchased by self-employed individuals, and small business insurance market reforms to make health coverage more affordable for small businesses. Included in this amendment were provisions from a bill introduced by the late Senator John Chafee, legislation which I

cosponsored and which was previously proposed by Senators Bentsen and Durenberger. When then-majority leader Mitchell argued that the health care amendment I was proposing did not belong on that bill, I offered to withdraw the amendment if he would set a date certain to take up health care, similar to an arrangement made on product liability legislation, which had been placed on the calendar for September 8, 1992. The majority leader rejected that suggestion, and the Senate did not consider comprehensive health care legislation during the balance of the 102nd Congress. My July 29, 1992 amendment was defeated on a procedural motion by a vote of 35 to 60, along party lines.

The substance of that amendment, however, was adopted later by the Senate on September 23, 1992, when it was included in a Bentsen/Durenberger amendment which I cosponsored to broaden tax legislation, H.R. 11. This amendment, which included essentially the same self-employed tax deductibility and small group reforms I had proposed on July 29 of that year, passed the Senate by voice vote. Unfortunately, these provisions were later dropped from H.R. 11 in the House-Senate conference.

On August 12, 1992, I introduced legislation entitled the Health Care Affordability and Quality Improvement Act of 1992, S. 3176, that would have enhanced informed individual choice regarding health care services by providing certain information to health care recipients, would have lowered the cost of health care through use of the most appropriate provider, and would have improved the quality of health care.

On January 21, 1993, the first day of the 103rd Congress, I introduced the Comprehensive Health Care Act of 1993, S. 18. This legislation consisted of reforms that our health care system could have adopted immediately. These initiatives would have both improved access and affordability of insurance coverage and would have implemented systemic changes to lower the escalating cost of care in this country.

On March 23, 1993, I introduced the Comprehensive Access and Affordability Health Care Act of 1993, S. 631, which was a composite of health care legislation introduced by Senators Cohen, Kassebaum, Bond, and McCain, and included pieces of my bill, S. 18. I introduced this legislation in an attempt to move ahead on the consideration of health care legislation and provide a starting point for debate. As I noted earlier, I was precluded by Majority Leader Mitchell from obtaining Senate consideration of my legislation as a floor amendment on several occasions. Finally, on April 28, 1993, I offered the text of S. 631 as an amendment to the pending Department of the Environment Act, S. 171, in an attempt to urge the Senate to act on health care reform. My amendment was defeated 65 to 33 on a procedural motion, but the Senate had finally been forced to contemplate action on health care reform.

On the first day of the 104th Congress, January 4, 1995, I introduced a slightly modified version of S. 18, the Health Care Assurance Act of 1995, which contained provisions similar to those ultimately enacted in the Kassebaum-Kennedy legislation, including insurance market reforms, an extension of the tax deductibility of health insurance for the self employed, and tax deductibility of long term care insurance.

I continued these efforts in the 105th Congress, with the introduction of Health Care Assurance Act of 1997, S. 24, which included market reforms similar to my previous proposals with the addition of a new Title I, an innovative program to provide vouchers to States to cover children who lack health insurance coverage. I also introduced Title I of this legislation as a stand-alone bill, the Healthy Children's Pilot Program of 1997, S. 435, on March 13, 1997. This proposal targeted the approximately 4.2 million children of the working poor who lacked health insurance at that time. These are children whose parents earn too much to be eligible for Medicaid, but do not earn enough to afford private health care coverage for their families.

This legislation would have established a $10 billion/5-year discretionary pilot program to cover these uninsured children by providing grants to States. Modeled after Pennsylvania's extraordinarily successful Caring and BlueCHIP programs, this legislation was the first Republican-sponsored children's health insurance bill during the 105th Congress.

I was encouraged that the Balanced Budget Act of 1997, signed into law on August 5, 1997, included a combination of the best provisions from many of the children's health insurance proposals throughout that Congress. The new legislation allocated $24 billion over 5 years to establish State Child Health Insurance Program, funded in part by a slight increase in the cigarette tax.

During the 106th, 107th, 108th Congresses, I again introduced the Health Care Assurance Act. These bills contained similar insurance market reforms, as well as new provisions to augment the new State Child Health Insurance Program, to assist individuals with disabilities in

maintaining quality health care coverage, and to establish a National Fund for Health Research to supplement the funding of the National Institutes of Health. All these new initiatives, as well as the market reforms that I supported previously, work toward the goals of covering more individuals and stemming the tide of rising health costs.

My commitment to the issue of health care reform across all populations has been consistently evident during my tenure in the Senate, as I have come to the floor and offered health care reform bills and amendments on countless occasions. I will continue to stress the importance of the Federal Government's investment in and attention to the system's future.

As my colleagues are aware, I can personally report on the miracles of modern medicine. In 1993, an MRI detected a benign tumor, meningioma, at the outer edge of my brain. It was removed by conventional surgery, with 5 days of hospitalization and 5 more weeks of recuperation. When a small regrowth was detected by a follow-up MRI in June 1996, it was treated with high powered radiation using a remarkable device called the "Gamma Knife." I entered the hospital on the morning of October 11, 1996, and left the same afternoon, ready to resume my regular schedule.

In July 1998, I was pleased to return to the Senate after a relatively brief period of convalescence following heart bypass surgery. This experience again led me to marvel at our health care system and made me more determined than ever to support Federal funding for biomedical research and to support legislation which will incrementally make health care available to all Americans.

In February 2005, I received tests at Thomas Jefferson University Hospital for persistent fevers and enlarged lymph nodes under my left arm and above my left clavicle. The testing involved a biopsy of a lymph node and biopsy of bone marrow. The biopsy of the lymph node was positive for Hodgkin's disease; however the bone marrow biopsy showed no cancer. A follow up PET scan and MRI at the University of Pennsylvania Abramson Cancer Center established that I had stage IVB Hodgkin's disease. After successful chemotherapy treatment I received a "clean bill of health."

Three years later, I received the test results from a routine PET scan, which showed a mild recurrence of Hodgkin's disease. I was once again undertook a chemotherapy regimen, which I have recently successfully completed.

My concern about health care has long pre-dated my own personal benefits from diagnostic and curative procedures. As I have previously discussed, my concern about health care began many years ago and has been intensified by my service on the Appropriations Subcommittee on Labor, Health and Human Services, and Education (LHHS).

My own experience as a patient has given me deeper insights into the American health care system beyond my perspective from the U.S. Senate. I have learned: (1) patients sometimes have to press their own cases beyond doctors' standard advice; (2) greater flexibility must be provided on testing and treatment; (3) our system has the resources to treat the 47 million

Americans currently uninsured; and (4) all Americans deserve the access to health care from which I and others with coverage have benefited.

I believe we have learned a great deal about our health care system and what the American people are willing to accept in terms of health care coverage provided by the Federal Government. The message we heard loudest was that Americans do not want the government to have a single payer government operated system.

While I would have been willing to cooperate with the Clinton administration in addressing this Nation's health care problems, I found many areas where I differed with President Clinton's approach to solutions. I believe that the proposals would have been deleterious to my fellow Pennsylvanians, to the American people, and to our health care system as a whole. Most importantly, as the President proposed in 1993, I did not support creating an expansive new government bureaucracy.

On this latter issue, I first became concerned about the potential growth in bureaucracy in September 1993 after reading the President's 239-page preliminary health care reform proposal. I was surprised by the number of new boards, agencies, and commissions, so I asked my Legislative Assistant, Sharon Helfant, to make me a list of all of them. Instead, she decided to make a chart. The initial chart depicted 77 new entities and 54 existing entities with new or additional responsibilities.

When the President's 1,342-page Health Security Act was transmitted to Congress on October 27, 1993, my staff reviewed it and found an increase to 105 new agencies, boards, and commissions and 47 existing departments, programs and agencies with new or expanded jobs. This chart received national attention after being used by Senator Bob Dole in his response to the President's State of the Union address on January 24, 1994.

The response to the chart was tremendous, with more than 12,000 people from across the country contacting my office for a copy; I still receive requests for the chart. Groups and associations, such as United We Stand America, the American Small Business Association, the National Federation of Republican Women, and the Christian Coalition, reprinted the chart in their publications--amounting to hundreds of thousands more in distribution. Bob Woodward of the Washington Post later stated that he thought the chart was the single biggest factor contributing to the demise of the Clinton health care plan. And during the November 1996 election, my chart was used by Senator Dole in his presidential campaign to illustrate the need for incremental health care reform.

The reforms we must enact need to encompass all areas of health. This must start with preventive health care and wellness programs. This starts at birth with prenatal care. We know that in most instances, prenatal care is effective in preventing low-birth-weight babies. Numerous studies have demonstrated that low birth weight does not have a genetic link, but is instead most often associated with inadequate prenatal care or the lack of prenatal care. It is a human tragedy for a child to be born weighing 16 ounces with attendant problems which last a lifetime. I first saw one pound babies in 1984 and I was astounded to learn that Pittsburgh, PA,

had the highest infant mortality rate of African-American babies of any city in the United States. I wondered how that could be true of Pittsburgh, which has such enormous medical resources. It was an amazing thing for me to see a one pound baby, about as big as my hand. However, I am pleased to report that as a result of successful prevention initiatives like the Federal Healthy Start program, Pittsburgh's infant mortality has decreased 24 percent.

To improve pregnancy outcomes for women at risk of delivering babies of low birth weight and to reduce infant mortality and the incidence of low-birth-weight births, as well as improving the health and well-being of mothers and their families, I initiated action that led to the creation of the Healthy Start program in 1991. Working with the first Bush administration and Senator Harkin, as chairman of the Appropriations Subcommittee, we allocated $25 million in 1991 for the development of 15 demonstration projects. This number grew to 75 in 1998, to 96 projects in 2008. For fiscal year 2008, we secured $99.7 million for this vital program.

To help children and their families to truly get a healthy start requires that we continue to expand access to Head Start. This important program provides comprehensive services to low income children and families, including health, nutritional and social services that children need to achieve the school readiness goal of Head Start. I have strongly supported expanding this program to cover more children and families. Since fiscal year 2000, funding for Head Start has increased from $5.3 billion to the 2008 level of $6.9 billion. Additional funding has extended the reach of this important program to over 1 million children.

The LHHS Appropriations bill also has made great strides in increasing funding for a variety of public health programs, such as breast and cervical cancer prevention, childhood immunizations, family planning, and community health centers. These programs are designed to improve public health and prevent disease through primary and secondary prevention initiatives. It is essential that we invest more resources in these programs now if we are to make any substantial progress in reducing the costs of acute care in this country.

As Ranking Member and Chairman of the LHHS Appropriations Subcommittee, I have greatly encouraged the development of prevention programs which are essential to keeping people healthy and lowering the cost of health care in this country. In my view, no aspect of health care policy is more important. Accordingly, my prevention efforts have been widespread.

I joined my colleagues in efforts to ensure that funding for the Centers for Disease Control and Prevention, CDC, increased from $2.3 billion in 1997 to $6.375 billion in fiscal year 2008. We have also worked to increase funding for CDC's breast and cervical cancer early detection program to $200.8 million in fiscal year 2008.

I have also supported programs at CDC which help children. CDC's childhood immunization program seeks to eliminate preventable diseases through immunization and to ensure that at least 90 percent of 2-year-olds are vaccinated. The CDC also continues to educate parents and caregivers on the importance of immunization for children under 2 years old. Along with my colleagues on the Appropriations Committee, I have helped ensure that funding for this

important program together with the complementary Vaccines for Children Program has grown from $914 million in 1999 to $3.2 billion in fiscal year 2008.

While vaccines are critical for prevention we must be prepared for an influenza pandemic. To ensure that America is properly prepared for such a pandemic the LHHS Appropriations bills have provided $6 billion since 2005. This funding provides development and purchase of vaccines, antivirals, necessary medical supplies, diagnostics, and other surveillance tools.

We have also strengthened funding for Community Health Centers, which provide immunizations, health advice, and health professions training. These centers, administered by the Health Resources and Services Administration, provide a critical primary care safety net to rural and medically underserved communities, as well as uninsured individuals, migrant workers, the homeless, residents of public housing, and Medicaid recipients. Funding for Community Health Centers has increased from $1 billion in fiscal year 2000 to $3.2 billion in fiscal year 2008.

Increases in research, education and treatment in women's health have been of particular importance to me. In 1998, I cosponsored the Women's Health Research and Prevention Amendments, which were signed into law later that year. This bill revised and extended certain programs with respect to women's health research and prevention activities at the National Institutes of Health and the Centers for Disease Control and Prevention.

In 1996, I also cosponsored an amendment to the Fiscal Year 1997 VA-HUD Appropriations bill, which required that health plans provide coverage for a minimum hospital stay for a mother and child following the birth of the child. This bill became law in 1996.

In 2005, I introduced the Gynecologic Cancer Education and Awareness Act to increase education of gynecological cancer so that women would be able to recognize cancer warning signs and seek treatment. This legislation became law in 2007.

I have also been a strong supporter of funding for AIDS research, education, and prevention programs.

During the 101st and 104th Congresses, I cosponsored the Ryan White CARE Reauthorization Act, which provided federal funds to metropolitan areas and states to assist in health care costs and support services for individuals and families affected by acquired immune deficiency syndrome, AIDS, or infection with the human immunodeficiency virus, HIV. Those bills became law in 1990 and 1996 respectively.

Funding for Ryan White AIDS programs has increased from $757.4 million in 1996 to $2.14 billion for fiscal year 2008. That includes $794 million for the AIDS Drug Assistance Program, ADAP, to help low-income individuals afford life saving drugs. AIDS research at the NIH totaled $742.4 million in 1989, and has increased to an estimated $2.91 billion in fiscal year 2008.

Veterans provide an incredible service in defending our country and providing them with quality health care is critical. During the 102nd Congress, I cosponsored an amendment to the Veterans' Medical Programs Amendments of 1992, which included improvements to health and mental health care and other services to veterans by the Department of Veterans Affairs. This bill became law in 1992.

During the 106th Congress, I sponsored the Veterans Benefits and Health Care Improvement Act of 2000, which increased amounts of educational assistance for veterans under the Montgomery GI Bill and enhanced health programs. This bill became law in 2000.

I also sponsored the Department of Veterans Affairs Long-Term Care and Personnel Authorities Enhancement Act, which improved and enhanced the provision of health for veterans. This bill became law in 2003.

In the 108th Congress, I introduced the Veterans Health Care, Capital Asset and Business Improvement Act of 2003, which upon becoming law in December 2003 enhanced the provision of health care for veterans by improving authorities relating to the administration of personnel at the VA.

In June 2004, I introduced the Department of Veterans Affairs Health Care Personnel Enhancement Act, which simplified pay provisions for physicians and dentists and authorized alternate work schedules and pay scales for nurses to improve recruitment and retention of top talent. The bill was signed into law in December 2004.

To increase the portability of insurance, in 1996, I cosponsored the Health Coverage Availability and Affordability Act, which improved the portability and continuity of health insurance coverage in the group and individual markets, combated waste, fraud, and abuse in health insurance and health care delivery, promoted the use of medical savings accounts, improved access to long-term care services and coverage, and simplified the administration of health insurance. This bill became law in 1996.

Statistics show that 27 percent of Medicare expenditures occur during a person's last year of life and beyond the last year of life, a tremendous percentage of medical costs occur in the last month, in the last few weeks, in the last week, or in the last few days.

The issue of end of life treatment is such a sensitive subject and no one should decide for anybody else what that person should have by way of end-of-life medical care. What care ought to be available is a very personal decision. However, living wills give an individual an opportunity to make that judgment, to make a decision as to how much care he or she wanted near the end of his or her life and that is, to repeat, a matter highly personalized for the individual.

Individuals should have access to information about advanced directives. As part of a public education program, I included an amendment to the Medicare Prescription Drug and Modernization Act of 2003 which directed the Secretary of Health and Human Services to include in its annual “Medicare And You” handbook, a section that specifies information on

advance directives and details on living wills and durable powers of attorney regarding a person's health care decisions.

As Ranking Member and Chairman of the Labor, Health and Human Services, and Education Appropriations Subcommittee, I have worked to provide much-needed resources for hospitals, physicians, nurses, and other health care professionals.

An adequate number of health professionals, including doctors, nurses, dentists, psychologists, laboratory technicians, and chiropractors is critical to the provision of health care in the United States. I have worked to provide much needed funding for health professional training and recruitment programs. In fiscal year 2008, these vital programs received $334 million. Nurse education and recruitment alone has been increased from $58 million in fiscal year 1996 to $149 million in fiscal year 2008.

Differences in reimbursement rates between rural and urban areas have led to significant problems in health professional retention. During the debate on the Balanced Budget Refinement Act, which passed as part of the fiscal year 2001 consolidated appropriations bill, I attempted to reclassify some Northeastern hospitals in Pennsylvania to a Metropolitan Statistical Area with higher reimbursement rates. Due to the large volume of requests from other states, we were not able to accomplish these reclassifications for Pennsylvania. However, as part of the FY 2004 Omnibus Appropriations bill, I secured $7 million for twenty northeastern Pennsylvania hospitals affected by area wage index shortfalls.

As part of the Medicare Prescription Drug and Medicare Improvement Act of 2003, which passed the Senate on November 25, 2003, a $900 million program was established to provide a one-time appeal process for hospital wage index reclassification. Thirteen Pennsylvania hospitals were approved for funding through this program in Pennsylvania. This program has been extended on several occasions and has provided a total of $164.1 million for Pennsylvania hospitals.

The National Institutes of Health (NIH) are the crown jewels of the Federal Government and have been responsible for enormous strides in combating the major ailments of our society including heart disease, cancer, Alzheimer's, and Parkinson's diseases. The NIH provides funding for biomedical research at our Nation's universities, hospitals, and research institutions. I led the effort to double funding for the NIH from 1998 through 2003. Since I became chairman in 1996, funding for the NIH has increased from $12 billion in fiscal year 1996 to $30.2 billion in the fiscal year 2009 Senate LHHS Appropriations bill.

Regrettably, Federal funding for NIH has steadily declined from the $3.8 billion increase provided in 2003, when the 5-year doubling of NIH was completed, to only $328 million in fiscal year 2008. The shortfall in the President's fiscal year 2009 budget due to inflationary costs alone is $5.2 billion. To provide that $5.2 billion in funding, I recently introduced with Senator Harkin, the NIH Emergency Supplemental Appropriations Act. This supplemental funding would improve the current research decline, which is disrupting progress, not just for today, but for years to come.

In 1970, President Nixon declared war on cancer. Had that war been prosecuted with the same diligence as other wars, my former chief of staff, Carey Lackman, a beautiful young lady of 48, would not have died of breast cancer. One of my very best friends, a very distinguished federal judge, Chief Judge Edward R. Becker, would not have died of prostate cancer. All of us know people who have been stricken by cancer, who have been incapacitated with Parkinson's or Alzheimer's, who have been victims of heart disease, or many other maladies.

The future of medical research must include embryonic stem cell research. I first learned about embryonic stem cell research in November 1998 and held the first Congressional hearing in December of that year. Since that time I have held nineteen more hearings on this important subject. Embryonic stem cells have the greatest promise in research because they have the ability to become any type of cell in the human body.

During the 109th Congress, the House companion bill to S.471, the Stem Cell Research Enhancement Act, was passed by Congress, but vetoed by President Bush. The vote to override the veto in the House failed. The legislation would expand the number of stem cell lines that are eligible for federally funded research, thereby accelerating scientific progress toward cures and treatments for a wide range of diseases and debilitating health conditions.

In the 110th Congress, S. 5, the Stem Cell Research Enhancement Act, of which I am a lead cosponsor and is identical to the 109th Congress legislation, was passed by Congress, but a vote to override the veto in the House again failed.

During the course of our stem cell hearings, we have learned that over 400,000 embryos are stored in fertility clinics around the country. If these frozen embryos were going to be used for in vitro fertilization, I would support that over research. In fact, I have provided $3.9 million in fiscal year 2008 to create an embryo adoption awareness campaign. Most of these embryos will be discarded and I believe that instead of just throwing these embryos away, they hold the key to curing and treating diseases that cause suffering for millions of people.

The many research, training and education programs that are supported by the federal government all contribute to this nation's efforts to provide the best prevention and treatment for all Americans. But without access to health care, these efforts will be lost. But with the plan outlined in the Health Americans Act, we can provide health care coverage for the 47 million uninsured Americans. This bipartisan bill is where the health insurance reform debate needs to begin -- with a market based approach to reforming health insurance. The time has come for concerted action in this arena. I urge my colleagues to take action on this important issue.